DOCUMENT RESUME

ED 390 068 CS 215 177

AUTHOR Munger, Roger H.
TITLE Ethos and Medical Narratives: How Narratives Written by Emergency Medical Personnel Reflect Professional Authority and Affect Patient Care.
PUB DATE Jul 95
NOTE 12p.; Paper presented at the Annual Penn State Conference on Rhetoric and Composition (14th, University Park, PA, July 12-15, 1995).
PUB TYPE Reports - Evaluative/Feasibility (142) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Audience Awareness; Discourse Analysis; *Emergency Medical Technicians; Jargon; *Persuasive Discourse; *Professional Training; Recordkeeping; *Technical Writing
IDENTIFIERS *Medical Writing; *Professional Behavior; Report Format; Rhetorical Strategies; Run Reports (Emergency Medical Technicians)

ABSTRACT

Since written reports are completed on most calls to which emergency medical technicians (EMTs) respond, report writing is an important part of their professional lives. Discourse analysis focused on how EMTs establish professional authority using specific rhetorical strategies when completing "run reports." One way of understanding the role of run reports in emergency care is that of a "charter document" which makes official certain ways of seeing and precludes other ways. Like medical journal articles, run reports must be persuasive to convince emergency department staff and quality review boards that their findings are credible and reliable. One common feature of the run reports analyzed was the inclusion of what some healthcare providers term "excuses." Instructions listed in New York Health Department's "EMS Program Student Manual" for completing run reports make no mention of including reasons for not following protocols, but excuses were usually found at the end of the narratives and explained why something was not done that should have been done. In the reports examined, EMTs were dissociated from their patients, as befitting their professional authority. Mastery of jargon is one indicator of expertise and authority--how EMTs state their findings is very important. Like other medical writers, EMTs are expected to use unadorned language. The narrative section, two short objective and subjective assessments, summarizes the emergency call. Examining how report forms influence issues of authority, credibility, and professionalism in the EMS community is the first step in teaching EMTs how to successfully produce the knowledge required on written reports. (PA)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
R Munger
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Roger H. Munger
Rensselaer Polytechnic Institute
Department of Language, Literature, and Communication

ED 390 068

Title: Ethos and Medical Narratives: How Narratives Written by Emergency Medical Personnel Reflect Professional Authority and Affect Patient Care

Introduction

Since written reports are completed on almost every call to which an emergency medical technician (EMT) responds, report writing is an important and large part of his or her professional life. Because written communication plays such an important role when a patient is transfered to the next level of care, it is not surprising to find that the professional reputations of new EMTs and patient care are often determined by how effective EMTs are in establishing their ethos through their writing.

EMTs' power, like physicians' power, "derives from their ability to create 'objective' representations" of the patient's condition (Cicourel, 1985, p. 170). Yet, even these "objective representations" of "fact" are problematic because the "reporting itself is never innocent, but always laden with some kind of value, with some attempt to direct the attention to one thing rather than another" (Segal, 1993, p. 522). Faced with a universe of possible way to represent patient care in writing, EMTs must decide what to write and how it should be expressed. In this paper, I will discuss how emergency medical technicians establish their professional authority using specific rhetorical strategies when completing run reports. In particular, I will focus on how narrative sections of run reports establish an EMT's ethos and, in some instances, may adversely affect patient care.

CS215177

BEST COPY AVAILABLE

A useful way of understanding the role of run reports in emergency care is that of a charter document. Lucille Parkinson McCarthy (1991) in her article "A Psychiatrist Using DSM-III" describes what constitutes an organizations "charter document": A charter document of a group "establishes an organizing framework that specifies what is significant and draws people's attention to certain rules and relationships" (p. 359). Run reports, a charter document in the EMS (Emergency Medical Services) field, make official certain ways of seeing and precludes other ways. The form itself reveals what the EMS community values. Richard Coe (1987) in "An Apology for Form" remarks, "For a form implies a strategy of response, an attitude, a way of sorting factors, sizing up situations" (p. 19). Or, as Anthony Pare (1993) believes, the form "regularizes meaning by replicating, as closely as possible, the processes of composition and interpretation" (p. 113). This regularlization of writing run reports not only ensures certain knowledge by requiring it but also defines a relatively rigid sequence of steps EMTs must follow when writing reports. It is in this highly constrained environment that EMTs are left to establish their authority.

Professional Authority

Like articles in medical journals, run reports must be persuasive. EMTs must convince emergency department staff (i.e., doctors and nurses) that their findings are credible and reliable. They must also convince quality control review boards that they are performing their duties at or above the minimum level of competency set by state and national certifying agencies. However, unlike medical journals, the immediate consequences for failing to persuade are much greater for EMTs. Failure to

persuade a medical journal's readership means that the work is ignored. Failing to persuade his or her readers for the EMT means that the patient does not get the necessary care in the fastest time possible. In fact, a failure to persuade may lead to a patient's death. Because emergency department staff are not "at the scene" of an accident, they must rely on the EMT's description of the scene. EMTs at a motor vehicle accident, for example, see the mangled cars--an engine pushed into the back seat--and must persuade the emergency department that even though the patient is seemingly "OK" the car he or she was driving suggests the possibility of massive spinal and internal injuries. Moreover, EMTs' personal reputations are at stake. The written text remains as evidence of their professionalism long after they transfer care and respond to the next 911 call. With such pressure to persuade, EMTs work hard at establishing their credibility and authority through their report writing.

The successful completion of run reports directly influence the way emergency department staffs, other patient care providers, and the public perceive an EMT's professionalism. A popular training manual by Grant et. al. (1994) reinforces the connection between reports and EMT professionalism: "If your [run report] and the face-to-face report you give is disjointed, illogical, or in need of being translated into medical terminology, the nurse or physician may lose respect for you as a professional and discount your information" (p. 687). The manner in which a run report is written helps to establish an EMT's ethos. Judy Segal (1993) writes, "The ethical argument, or the argument from the character of the speaker, is central to all persuasive discourse in medical writing" (p. 525) Likewise, the character of the EMT is central to the persuasive success of run reports. S. Michael Halloran (1982) in "Aristotle's Concept of

Ethos, or if not His Somebody Else's" defines ethos as "what we might call the argument from authority, the argument that says in effect, 'Believe me because I am the sort of person whose words you can believe'" (p. 59). The degree to which an EMT's report exhibits "the virtues most valued" by the emergency medical community often determines whether or not his or her medical findings will be accepted. Textual features valued in the emergency medical services community I studied include the use of excuses, dissociation from patients, and EMS jargon.

Excuses

One common feature of the run reports I analyzed was the inclusion of, what some healthcare providers term, excuses. The instructions listed in New York Health Department's EMS Program Student Manual for completing run reports make no mention of including reasons for not following protocols. However, in the run reports I examined, I discovered numerous instances of excuses. Excuses are usually found at the very end of the narratives and serve to explain why something was not done that should have been done. For example, New York state requires that three sets of vital signs (i.e., respiration, pulse, blood pressure, level of consciousness, pupil reactions, and skin appearance) be taken on each patient. For this ambulance squad, their excuses most commonly refer to the lack of vital signs. Consider the following excuses:

1. Note: Vitals incomplete due to pt. uncooperativeness.
2. Only 1 set of vitals taken due to constantly clearing pt. airway.
3. 7 min. call -- Not enough time.
4. No vitals because PT was sleeping.

The EMTs using the above excuses are trying to prevent their authority from being erroded due to a failure to follow state mandated protocols. Excuses 1 and 2 are most appropriate and would most likely not be viewed as unprofessional. Excuse 3 is less clear cut; seven minutes is usually long enough to take at least one set of vitals. And excuse 4 is clearly unacceptable. The person writing this excuse would severely harm his or her professional reputation and authority.

Dissociation from Patients

EMTs build their professional authority through their dissociation from their patients. Segal (1993) reports that direct emotional appeals are unconventional in medicine. In the run reports that I've looked at, the EMTs are similarly dissociated from the patients. They are seen as more "objective" and "professional." The ambulance crew as agents of action are typically absent in the subjective assessment, objective assessment, and comments that make up the narrative section of run reports. For example,

> [Subjective Assessment] Dispatched to an intoxicated pt. who was "twitching." Upon arrival found male lying on a bed. . . . Pt. stated that he drank beer, unknown quantity, very [Objective Physical Assessment] quickly. Pt. stated that he was trying to go to sleep when he began "twitching" . . . .[Comments] Pt's body was contracting for ~1 sec at a time. Contractions occurred at random times. . . . Pt. placed on 02 via NRB@10LPM. O2 didn't appear to improve situation. . . .Vitals monitored. Pt. transported to hospital w/o change in state or incident. Long time on scene due to difficulty moving pt.

In the above example, the ambulance crew is absent. Instead of writing, for instance, "When we arrived" the writer chooses "Upon arrival." Although we know the patient was placed on oxygen, we can only assume

it was the ambulance crew who administered the oxygen. Facts such as "Pt's body was contracting for ~1 sec at a time" are presented in an objective manner. The third person point of view helps make the facts more objective and, consequently, the ambulance crew more professional.

On the other hand, unprofessional EMTs ignore community standards. One example of a poorly received comment on a run report read,

> I hope there is enough shit here for whoever reviews this.

The EMT who wrote this clearly violated the values of the EMS community. Besides the obvious disrespect present in the text, this EMT violates several other rules. For example, he uses the first person I and addresses his audiences directly. Both transgressions reduce his authority and destroy the objective veneer typical of run reports.

EMS Jargon

Part of the move from insider to outsider in the EMS community is learning the EMS jargon associated with the prehospital care of patients. The mastery of jargon is one indicator of an EMT's expertise and professional authority. How an EMT states his or her findings is very important. EMTs, like other medical writers, are expected to use language "unadorned by stylistic embellishment" (Segal, 1993, p. 526). The Journal of American Medical Association advices that "information must be presented with accuracy and clarity in manner that can be read easily and rapidly." This advice is especially pertinent to EMTs writing run reports when seconds count and a jumbled report can result in wasted efforts to discover what was already known. The use of appropriate jargon in a run

report both marks the writer as "one who knows his or her stuff"--one whose findings should not be ignored--and facilitates the transfer of information. Consider the following excerpt from a run report documenting an unknown illness:

> [Objective Physical Assessment] Pt A&O x 3, no LOC, - pt tenderness, lung sounds clear bilaterally. Pt reports pn was 9/10 before vomiting, 6/10 while enroute to hospital. Pt. c/o feeling cold, stated pn began ~ 2230.

The writer conveys a substantial amount of information in just a few words and marks herself as a professional. Emergency department staff reading this knew very quickly, for instance, that the patient was alert and oriented to her name, location, and time of day. The patient suffered no loss of consciousness and the EMT's physical assessment revealed no signs of point tenderness and clear lungs--all important information in the diagnosis and treatment of an unknown illness. She also indicates the severity of pain on a ten-point scale as reported by the patient. All of this marks her as a credible professional. Not only are these findings likely taken as fact, previous findings found elsewhere on the run report such as vital signs are also believed accurate.

Narratives

The objective and subjective assessment, known as the narrative section, are short summary pieces intended to persuade readers (i.e., the next level of care providers). These two sections summarize the emergency call. "Many synopses," Segal (1993) finds, "promise reports of both significance and priority" (p. 525). It is the run report and its narrative section that the emergency department staff must turn to when deciding what care the patient is to receive and when the patient must get

it. They are specifically looking for the significance of problem and the priority a patient must be given.

The purpose of the subjective assessment and objective physical assessment is to capture readers' attention--in some instances to persuade them that this patient is in need of immediate care and in other instances that the patient can wait. Similar to what Segal (1993) finds in medical journals, for EMTs "the strategic presentation of findings is one of the most 'available'. . . 'means of persuasion'" (523). EMTs must construct their professional authority from a collection of anomalous signs and symptoms. EMTs must build a persuasive argument from the events and details at the scene of the emergency. This construction of authority is an ongoing process as the EMT cares for the patient. Patients are described by a collection of subjective findings and objective measurements. At first, numbers are recorded: BP 120/80, pulse 120 and regular, respirations 18 and labored. The patient is defined by his chest pain, elevated blood pressure, and sweating. "Crushing chest pain" and "sugar problems" are reported by the patient.

The EMT transforms these findings into a narrative summary of "a possible AMI." Later, instrument traces such as a strip from ECG monitoring are also transformed into words. The physical reality of a six inch strip showing a line resembling an irregular picket fence is converted into writing: "ventricular fibrillation." Through the course of patient treatment, these signs and symptoms are transformed into a coherent presentation. In the end, the narrative--a story complete with characters, setting, action, point of view, dialogue, beginning, and end--describes a victim of an acute myocardial infarction.

Brady's Emergency Care (Grant et. al., 1994) refers to the creation of a run report as a story: "When hospital personnel review your form, you will often not be there to fill in any gaps in the information. Therefore, the story you have written must be as complete as possible" (p. 682). The key word in this quote is *story*. The report is a story complete with characters, setting, action, point of view, dialogue, a beginning, and an end:

> [Subjective Assessment] Upon arrival, Pt found sitting up against wall in bathroom, c/o severe pain in lower back. Pt states pain started ~1/2 hour prior to our arrival, w/ sudden onset. [Objective Physical Assessment] Pt states pain "comes and goes," is "sharp, stabbing." Pt also states this has never happened before. Exam reveals - chest pain, SOB, pain in quadrants. Abdomen soft and pliable w/ - rigidity or increased pain upon palpation. Pt has no other [Comments] pain. No change in back pain upon palpation. Pt A&O x 3, denies any sporting injuries or falls. Pt denies pregnancy, states last menstrual cycle normal, and this didn't mimic same pain. Pt states L lateral recumbent position reduces pain [Continuation Form: Additional History & Physical Exam Findings] Vitals assessed, O2 applied. Pt states O2 helped some in reducing pain & Dizz/Naus feeling. Pt placed in Reeves in L lateral recumbent position, secured, carried to stretcher, secured, loaded into rig. Pt monitored enroute w/o change in condition. Pt placed in Exam #2, w/ full report of pt care tot 412 ER-RN.

A story indeed. Readers know the setting for the story. For example, in the first scene the main character is sitting up against a wall in her bathroom and in the final scene in Hospital 412's Exam Room #2. Throughout the story, the patient makes statements and is assessed, secured, carried, and monitored. Moreover, readers get a sense of the drama at the scene. Once they arrive on the scene the EMTs attempt to find the cause of the patient's lower back pain. It's not a sporting injury. Not due to a fall. Not pregnancy. At the end of the narrative, the cause of the pain is still unknown; however, there has been some resolution. The patient is safely transported without incident to the hospital.

Narrative sections are not without their pitfalls. Because EMTs write their narratives with the outcomes already known, this opens the door to the possibility that EMTs may rearrange the "facts" for the sake of the "story." The jumbled, hectic flow of events through time and space is smoothed out into an acceptable narrative by the time it is recorded on the form. This retelling of the story may later compromise patient care. Seemingly irrelevant information, for instance, may intentionally be omitted because it does not "fit" the story. Other information may be rearranged chronologically to better match a "textbook" version of the emergency. This altered account may inadvertently mislead the next level of patient care providers.

Conclusion

In the specific case of run reports, the issue of authority influences the decisions EMTs make while treating patients. This issue illustrates that documentation of patient care is the result of complex interactions between report forms, patients, EMS community, individual assumptions and experiences, and larger social forces. New interactive methods of electronic documentation that allow for more accurate and detailed reports will certainly affect EMTs authority and patient care in the future. Examining how report forms influence issues of authority, credibility, and professionalism in the EMS community is the first step in teaching EMTs how to successfully produce the knowledge required on written reports by this community.

References

Cicourel, A. V. (1985). Text and discourse. Annual Review of Anthropology, 14, 159-85.

Coe, R. (1987). An apology for form; Or who took form out of the process? College English ,49(1), 13-28.

Grant, H. D., R. H. Murray & J. D. Bergeron. (1994). Emergency care. Englewood Cliffs: Brady.

Halloran, S. M. (1982). Aristotle's concept of ethos, or if not his somebody else's. Rhetoric Review ,1(1), 58-63.

McCarthy, L. P. (1991) A psychiatrist using DSM-III. In C. Bazerman & J. Paradis (Eds.), Textual dynamics of the professions: Historical and contemporary studies of writing in professional communities (pp. 358-78). Madison: U. of Wisconsin Press.

New York Dept. of Health. (1992-93). EMS program student manual. Albany: Health Research Inc.

Pare, A. (1993) Discourse regulations and the production of knowledge. In R. Spilka (Ed.), Writing in the Workplace (pp. 111-123). Carbondale: Southern Illinois UP.

Segal, J. (1993). Strategies of influence in medical authorship. Soc. Sci. Med., 37.4, pp. 521-530.